Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

STAR ANESTHESIA PA
SUITE 900
45 NORTHEAST LOOP
SAN ANTONIO TX 78216

Respondent Name
SAN ANTONIO ISD

Carrier's Austin Representative
Box Number 21

MFDR Tracking Number
M4-12-1185-01

MFDR Date Received
December 16, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We have received the following payment with the explanation of benefits and find that an error was made in your denial of this bill. This attached bill has been denied for absence of, or exceeded, precertification/authorization. As noted on our HCFA 1500 on line 23 (prior authorization number) this services was considered an emergency."

Amount in Dispute: $245.43

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Requestor is seeking reimbursement for date of service March 31, 2011 in the amount of $245.43. The date of service at issue is for manipulation under anesthesia. The Carrier denied the bill, as no pre-authorization was received for the procedure as required per Rule 134.600. The Requestor defines the procedure at issue as emergent per 133.2. The procedure at issue was not responsive to a 'sudden onset of a medical condition,' rather the claimant developed flexion contracture due to a delay in rehabilitation because the claimant was staying out of town following her surgery. The condition was dealt with upon her return from her convalescence and Requestor could have requested pre-authorization upon her return to San Antonio. The Respondent's position is that the procedure at issue was not an emergency and could have been pre-authorized prior to its performance."

Response Submitted by: Thornton, Biechlin, Segrato, Reynolds & Guerra, L.C.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
March 31, 2011	01380-AA	$245.43	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.600 sets out the guidelines for Preauthorization, Concurrent Review, and Voluntary Certification of Health Care.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - 197 – Precertification/authorization/notification absent.
   - This procedure on this date was previously reviewed
   - 18 – Duplicate claim/service
   - 193 – Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
   - This bill was reviewed through the IMO nurse prescreen process.

Issues

1. Did the requestor obtain preauthorization for the disputed services?
2. Did the requestor submit sufficient documentation to document an emergency?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §134.600 "(p) Non-emergency health care requiring preauthorization includes: (1) inpatient hospital admissions, including the principal scheduled procedure(s) and the length of stay; (2) outpatient surgical or ambulatory surgical services as defined in subsection (a) of this section."

   The requestor seeks reimbursement for anesthesia services billed with CPT code 01380-AA. The AMA CPT Code book defines CPT code 01380 as follows "Anesthesia for all closed procedures on knee joint." The requestor appended modifier AA to identify that the anesthesia services are performed personally by an anesthesiologist. The insurance carrier denied the disputed charge with denial reason code 197– Precertification/authorization/notification absent. The requestor indicates the following in their position summary "This patients [sic] injury resulted in diagnosis-pain in joint, lower leg. Initially the claim was billed out in error as diagnosis-contracture of pelvis which was an error on our behalf. As a result of his injury, this is considered an emergency by being a serious dysfunction of any body organ or part."
2. 28 Texas Administrative Code §133.2 "(4) Emergency--Either a medical or mental health emergency as follows: (A) a medical emergency is the sudden onset of a medical condition manifested by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: (i) placing the patient's health or bodily functions in serious jeopardy, or (ii) serious dysfunction of any body organ or part; (B) a mental health emergency is a condition that could reasonably be expected to present danger to the person experiencing the mental health condition or another person..."
3. The requestor submitted insufficient documentation to support an "emergency" as defined by 28 Texas Administrative Code §133.2. As a result, preauthorization was required and not obtained. Reimbursement for disputed CPT code 01380-AA rendered on March 31, 2011 cannot be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		November 7, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.